

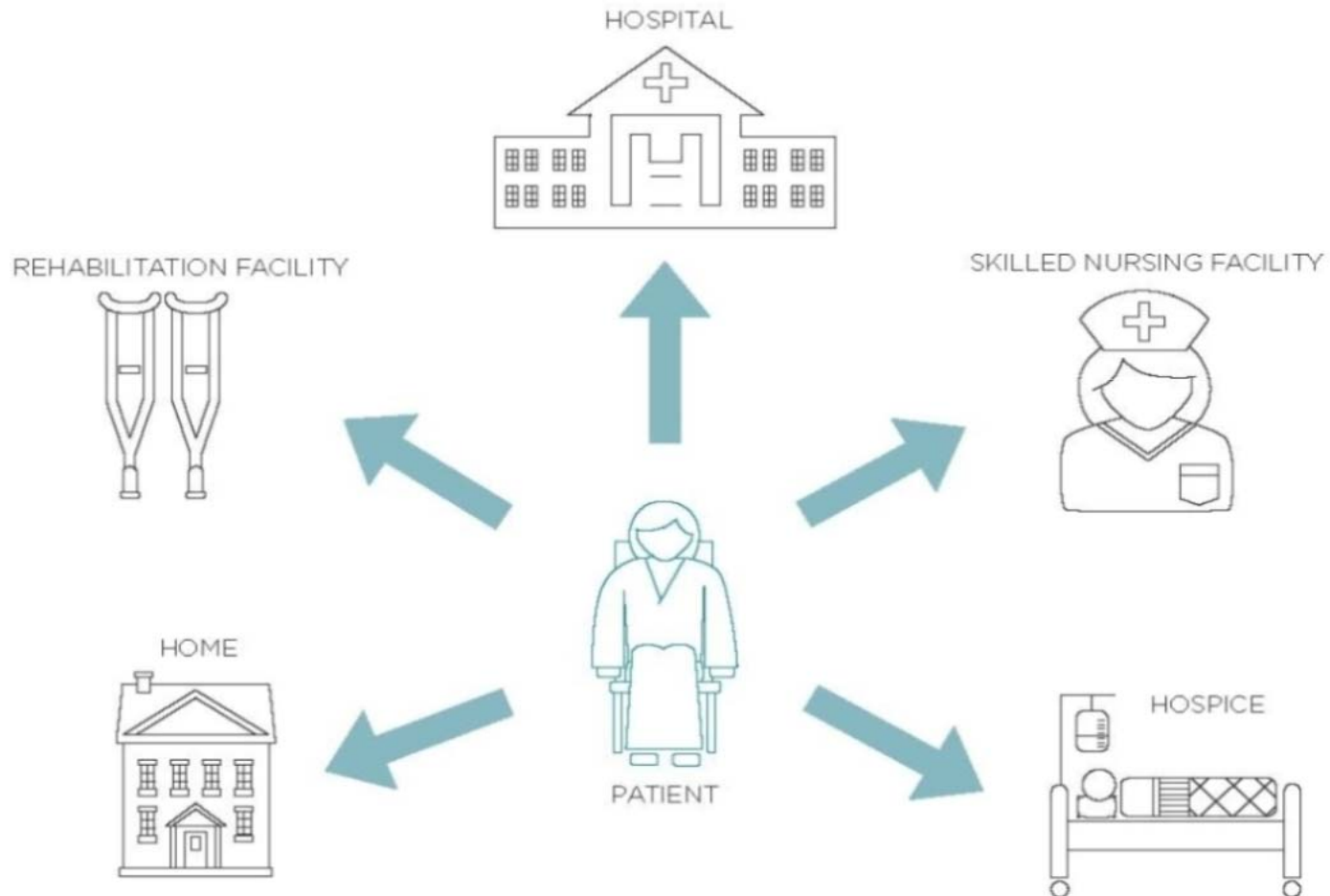


Best Practices for Care Transitions: *Engaging Emergency Departments and Urgent Care Centers*

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Who is missing?



Outline for today

- Role of QIOs
- The opportunity
- Safe Transitions Best Practices
- Other approaches
- Moving forward

What is a QIO?

- CMS-contracted network across the country
- Active in all healthcare settings
- Focused on
 - Patient safety
 - Healthcare quality
 - Beneficiary rights



Rhode Island's Safe Transitions Project

- Medicare-funded pilot, 2008-2011
 - Competitively awarded
 - Only 14 nationwide
 - Cross-setting
- Medicare-funded expansion, 2011-2014
 - All states
 - Building on prior work



Our vision

A healthcare system where patients and their caregivers understand their conditions and medications, know who to contact with questions (and when), and are supported by healthcare professionals who have access to the right information, at the right time.

Rhode Island's Safe Transitions Project

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Select interventions



- Five community coalitions
- On-site technical support for providers
- Statewide learning and action network
- Spread of the Safe Transitions Best Practices

Select interventions

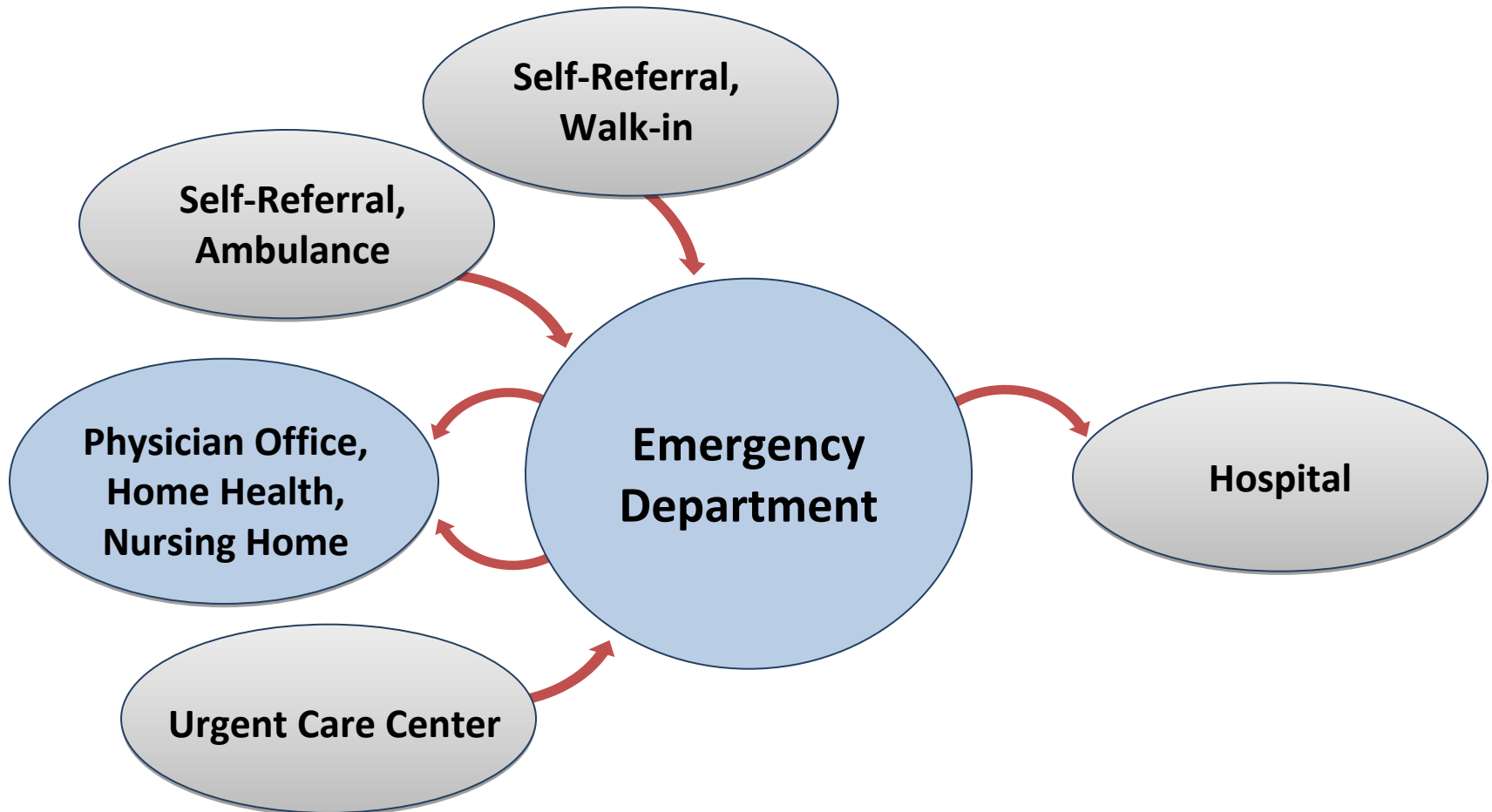


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Why Emergency Departments?

- 130 million ED visits a year
- High acuity of patients
- PCPs have to immediately assume care
 - Waste time requesting records
 - Incur cost, patient discomfort with repeat testing
- Default: refer patients back to the ED

Patient flow to and from the ED



What's the current status?

- 23% of PCPs always notified
- Variability in quality and consistency of information transfer
- Limited research
- No national guidelines



Can patients fill the gap?

- Limitations in discharge instructions
 - Given in as little as two minutes
 - No assessment of understanding
 - Missing key details
- Inconsistent patient comprehension or recall
- Variation in patient adherence to follow-up appointments or prescribed meds

Rhodes, 2004; Schoen, 2012; Vashi, 2011

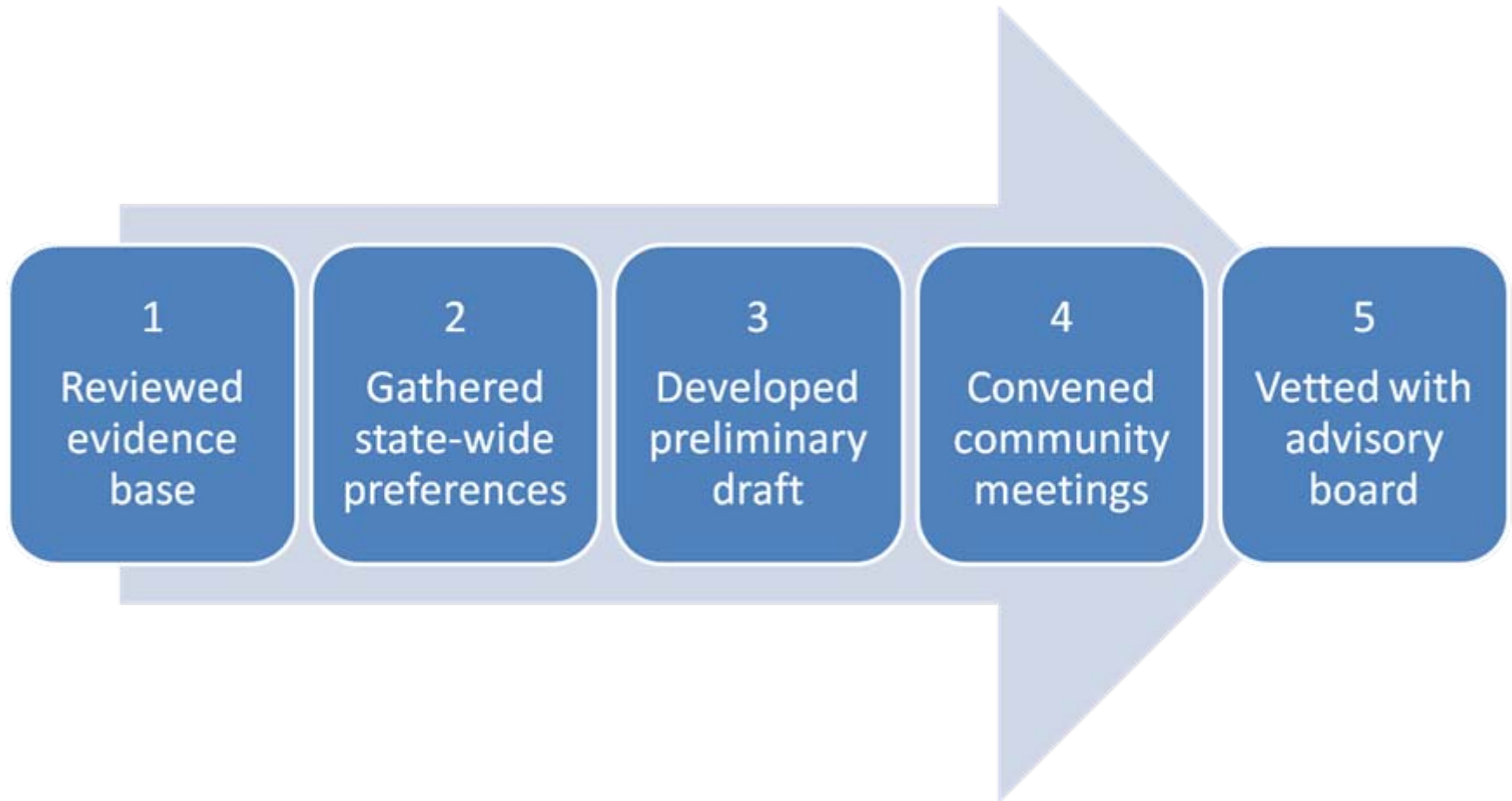
What's the solution?

- Identify best practices for care transitions
- Provide information needed to assume responsibility for patient care
- Detail expectations for communication
- Incorporate elements of patient activation
- Focus on actions within control of the setting

What is a Best Practice?

	ED	UCC	HHA	PCP	NH	Hosp
Timely, accurate information transfer:						
- To providers	X	X	X	X	X	X
- To patients	X	X	X	X	X	X
Patient activation	X	X	X	X	X	X
Med reconciliation	X	X	X	X	X	X
Timely follow-up	X	X	X	X	X	X
Responsiveness	X	X	X	X	X	X

How did we do it?



Safe Transitions Best Practices: ED

Document patients' primary care provider

Document patients' home care provider

Send summary clinical information to PCP/home care at discharge

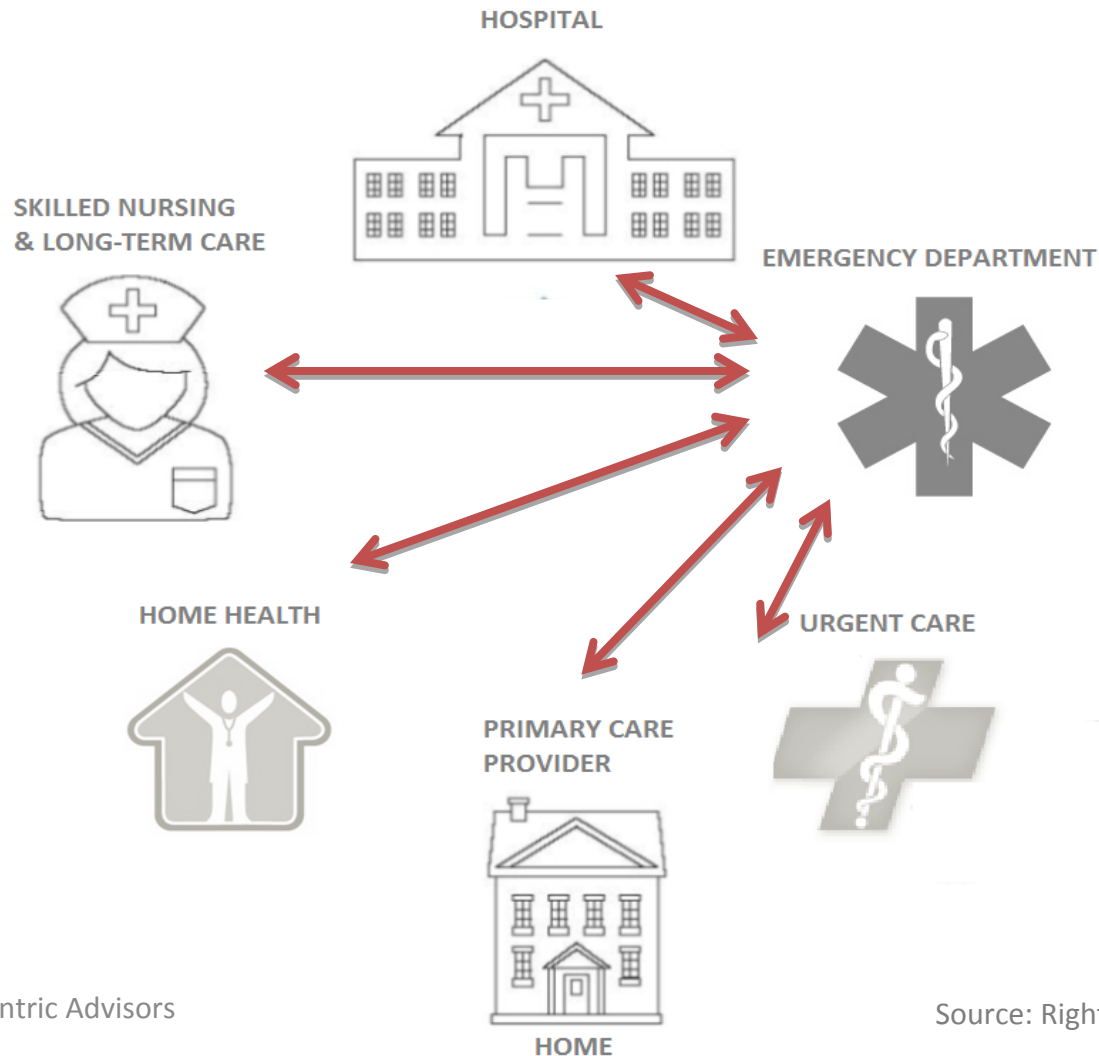
Send summary clinical information to receiving facility (e.g., NH)

Perform modified medication reconciliation

Provide effective education to patients and their families

Provide written discharge instructions

Asking for: reciprocal change



What are (some of) the barriers?



- Time and workflow concerns
- Little incentive to participate
- If viewed as “non-essential,” not prioritized
- Other competing new tasks
- Misaligned ED metrics

What can help remove barriers?

- Health system priorities
- Shared risk payment models
- Contracting requirements
- Focus on patient satisfaction as quality measure





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Original Contribution

Closing the loop: best practices for cross-setting communication at ED discharge

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ABSTRACT

Purpose: This study aimed to develop emergency department best practice guidelines for improved communication during patient care transitions.

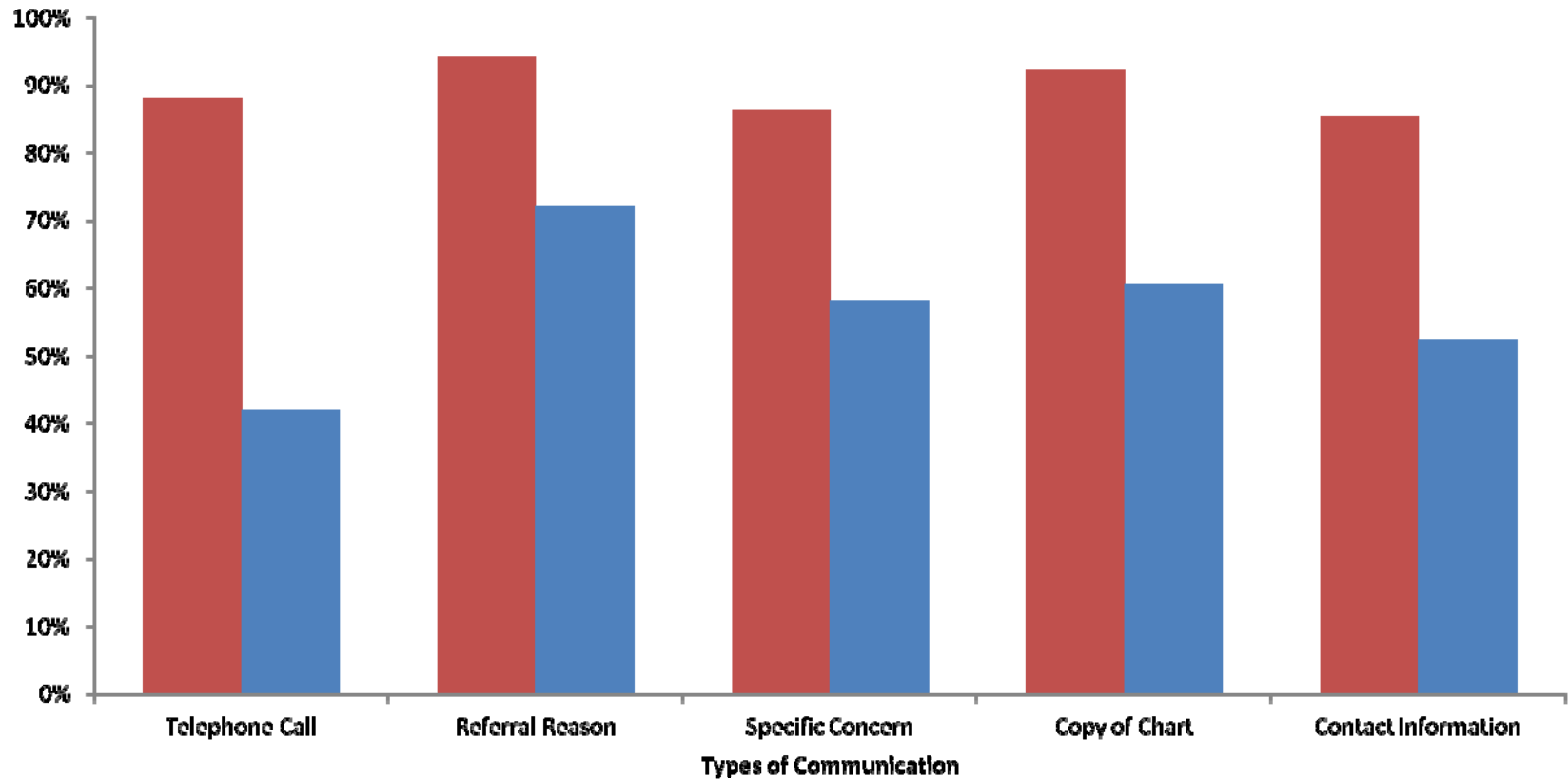
Basic Procedures: To our knowledge, there are no specific guidelines for communication at the point of transition from the emergency department to the community. In Rhode Island, we used a multistage collaborative quality improvement process to define best practices for emergency department care transitions. We reviewed the medical literature, consensus statements, and materials from national campaigns; gathered preferences from emergency medicine and primary care clinicians; and created guidelines that we vetted with emergency medicine clinicians and other key stakeholders.

Main Findings: Because we did not find any guidelines that globally addressed care transitions from the emergency department, we drew from studies on patient discharge instructions and extrapolated from the evidence base available for other, related settings. Our key outcome is a set of care transition best practices for emergency departments, which can be implemented to establish measurable, communitywide expectations for cross-setting clinician-to-clinician communication. They include obtaining information about patients' outpatient clinicians, sending summary clinical information to downstream clinicians, performing modified

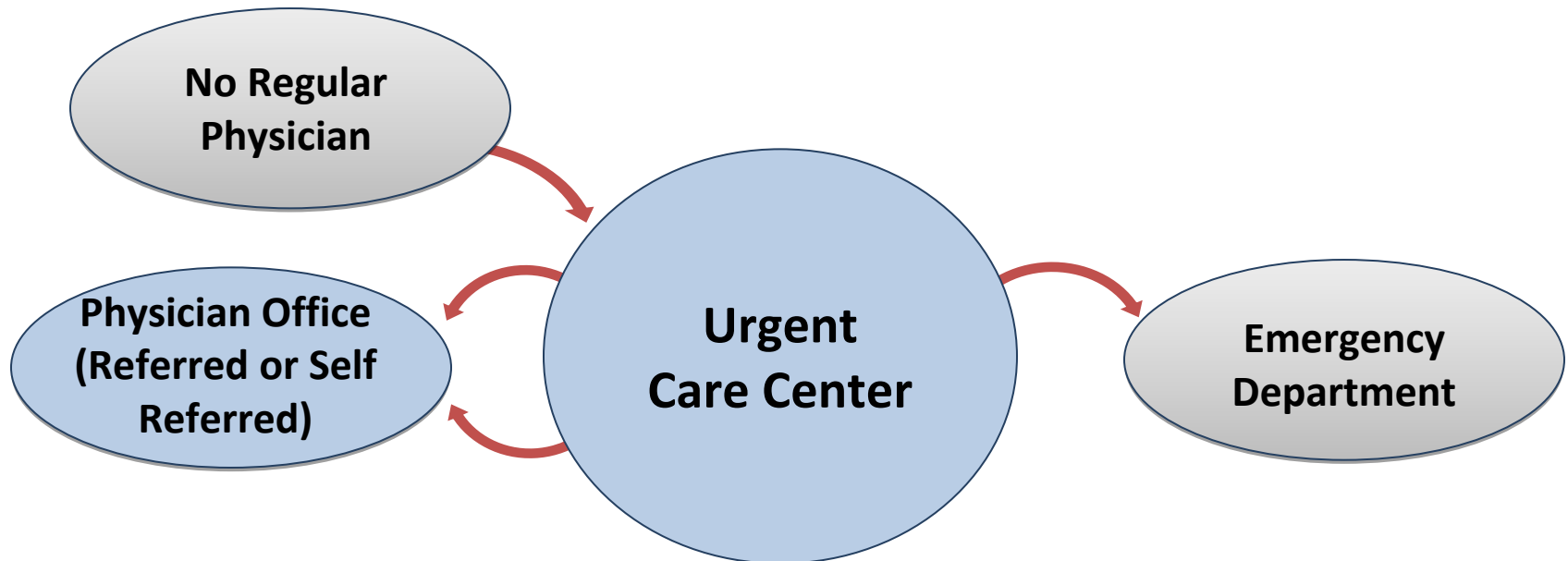
Why Urgent Care Centers?

- Patients increasingly using them
- Utilization can fragment care
- Many do not send information to PCPs at all
- Variation in type of information sent
- RI physicians identified this as a need

Communication is not adequate



Patient flow to and from an UCC



Safe Transitions Best Practices: UCC

Document patients' primary care provider

Document patients' home care provider

Send summary clinical information to PCP/home care at discharge

Send summary clinical information to the ED upon patient referral

Perform modified medication reconciliation

Provide effective education to patients and their families

Provide written discharge instructions

What are (some of) the barriers?

- Difficult to identify who they are
 - Many definitions and names
 - No central body
 - Varying regulatory requirements
- Many physician types
- Little incentive to participate
- Often not part of larger health systems
- Minimal scholarship, no specific journals



What can help remove barriers?

- Partnership with PCP offices for 24/7 access
- Strengthened reputation among ED/PCP → generates referrals
 - Contracting requirements by payers
 - In RI, could be condition of participation



What are others working on?

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Implementation of a Web-Based System to Improve the Transitional Care of Older Adults

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We constructed a bidirectional Web-based system to transmit critical patient information in real time between referring nursing homes and a university hospital emergency department (ED) to facilitate the care of patients referred to our ED. Our model was inexpensive, improved measures of information transfer, and increased provider satisfaction. **Key words:** *electronic medical records, quality improvement, transitional care*

IN 2004, The Centers for Disease Control and Prevention estimated that 8% of the US nursing home (NH) residents had an emer-

fer from multiple medical problems including cognitive impairment, these vulnerable individuals are often unable to transmit accurate

What are others working on?



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Strategies To Address Frequent Emergency Department Use

In many hospital emergency departments (EDs), a small percentage of patients account for a disproportionate share of visits and resources. Sometimes referred to as ED "super users," these individuals often lack a regular source of care and typically present to the ED with non-urgent conditions, often with a variety of underlying medical, behavioral, and psychosocial needs that cannot be addressed in the ED.

The **featured Innovations** describe three programs that implemented various strategies to provide, manage, and coordinate care and social services for individuals who are frequent ED

Also in This Issue:

Innovations >

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- **UPDATED:** Bicultural, Youth Development Program for At-Risk Latino Families Enhances Overall Health, Teen Birth Control Use, and Family Communication *with Expert Commentary*
- **UPDATED:** Pediatrician Training and In-Office Support Significantly Reduce Instances of Child Maltreatment

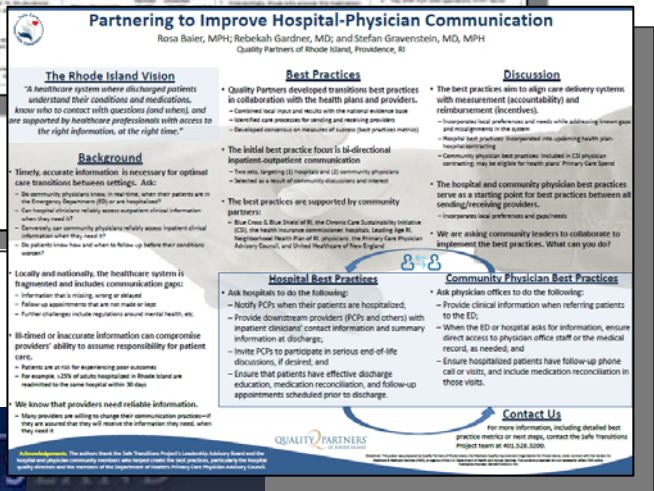
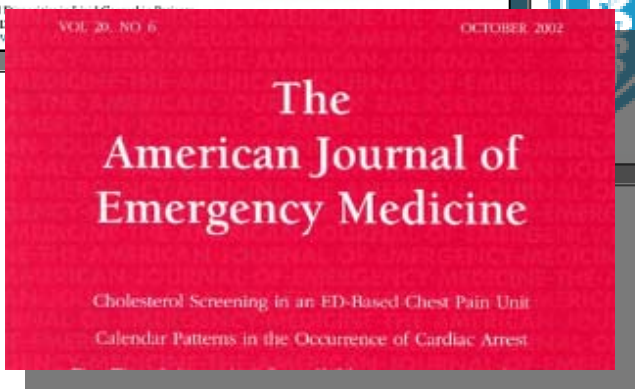
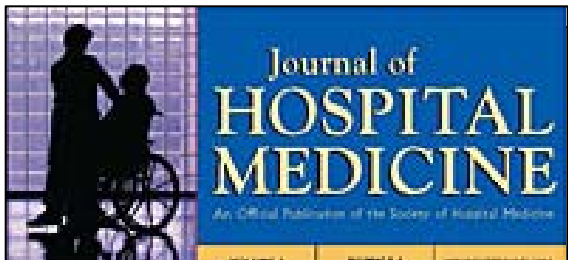
QualityTools >

What are lessons learned?

- Convene your partners early
 - Expect a period of storming and norming
 - Allow time to build foundation for behavior change
- Facilitate discussion
 - Let participants' voices prioritize next steps
- Use data to drive decision making
- Remember that it's all about relationships

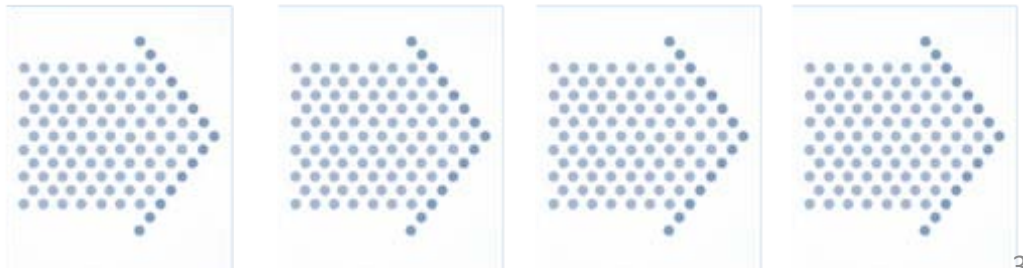
How to sustain and spread?

- Move local success to system success
 - Stakeholder consensus to align incentives
 - Change in expectations about communication
- Develop shared ownership
- Publish and present your work



As you look forward

- Employ QIO's role as a neutral convener
- Bring all healthcare settings to the table
- Invite the payers
- Align with other initiatives in the environment
- Harness emerging payment models





"The greatest opportunities for improving care transitions center around improving communication, building cross-setting relationships and redesigning our workflow."

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